COUNTY OF LOS ANGELES

Tracking #_____

Originating Agency_____

Original _____

Update _____

UNIVERSAL FACE SHEET

FAMILY MEMBERS - ADULT

1 Applicant or Caretaker's Name (First, Middle, Last) | Applicant/Caretaker Relationship to Children

What service(s) would you like to receive?

Adult: Child:

Social Security Number | Marital Status (check one) ☐ Married ☐ Never Married ☐ Living Together ☐ Widowed ☐ Divorced ☐ Separated (Date) _____ | Sex ☐ Male ☐ Female | Birth Date:

Employment Status ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Paid Training ☐ Hours per week: _____ | ☐ Blind ☐ Deaf ☐ Physically Disabled ☐ Date of Disability: _____ | Pregnant ☐ Yes ☐ No Due Date: _____ | Served in the U.S. Military ☐ Yes ☐ No

Home Address (Number and Street) | City | Zip Code

Mailing Address (If different from above) | City | Zip Code

(Area Code) Home Phone ( ) | (Area Code) Work Phone ( ) | (Area Code) Message Phone ( ) | Person with whom to leave a message: | Email Address:

Ethnic Group (Check all that apply) ☐ Alaskan Native ☐ American Indian ☐ Armenian ☐ Asian Indian ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hispanic/Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
☐ Other Asian or Pacific Islander (Specify): _____
☐ Other (Specify): _____

Primary Language ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ English ☐ Korean ☐ Mandarin ☐ Spanish ☐ Vietnamese
☐ Other (Specify): _____

2 Spouse/Other Parent (First Middle, Last) | Relationship to Children

Social Security Number | Marital Status (check one) ☐ Married ☐ Never Married ☐ Living Together ☐ Widowed ☐ Divorced ☐ Separated (Date) _____ | Sex ☐ Male ☐ Female | Birth Date:

Employment Status ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Paid Training ☐ Hours per week: _____ | ☐ Blind ☐ Deaf ☐ Physically Disabled ☐ Date of Disability: _____ | Pregnant ☐ Yes ☐ No Due Date: _____ | Served in the U.S. Military ☐ Yes ☐ No

Home Address (Number and Street) | City | Zip Code

Mailing Address (If different from above) | City | Zip Code

(Area Code) Home Phone ( ) | (Area Code) Work Phone ( ) | (Area Code) Message Phone ( ) | Person with whom to leave a message: | Email Address:

Ethnic Group (Check all that apply) ☐ Alaskan Native ☐ American Indian ☐ Armenian ☐ Asian Indian ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hispanic/Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White
☐ Other Asian or Pacific Islander (Specify): _____
☐ Other (Specify): _____

Primary Language ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ English ☐ Korean ☐ Mandarin ☐ Spanish ☐ Vietnamese
☐ Other (Specify): _____

LIST CHILDREN HERE (Family Members Only. List Other People on Question 6)

FAMILY MEMBERS - CHILDREN

3 Child's Name (First, Middle, Last) | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No Grade: _____ | Sex ☐ Male ☐ Female | Birth Date: | ☐ Blind ☐ Deaf ☐ Physically Disabled Date of Disability: _____ | Pregnant ☐ Yes ☐ No Due Date: _____

Father's Name | Is Father: ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed | Mother's Name | Is Mother: ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Child living in Home ☐ Yes ☐ No | Ethnic Group (Check all that apply) ☐ Alaskan Native ☐ American Indian ☐ Armenian ☐ Asian Indian ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hispanic/Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ Other Asian or Pacific Islander (Specify): _____ ☐ Other (Specify): _____

4 Child's Name (First, Middle, Last) | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No Grade: _____ | Sex ☐ Male ☐ Female | Birth Date: | ☐ Blind ☐ Deaf ☐ Physically Disabled Date of Disability: _____ | Pregnant ☐ Yes ☐ No Due Date: _____

Father's Name | Is Father: ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed | Mother's Name | Is Mother: ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Child living in Home ☐ Yes ☐ No | Ethnic Group (Check all that apply) ☐ Alaskan Native ☐ American Indian ☐ Armenian ☐ Asian Indian ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hispanic/Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ Other Asian or Pacific Islander (Specify): _____ ☐ Other (Specify): _____

CHILDREN CONT.

5 Child's Name (First, Middle, Last) | Relationship to Applicant

Social Security Number | In School ☐ Yes ☐ No Grade: _____ | Sex ☐ Male ☐ Female | Birth Date: | ☐ Blind ☐ Deaf ☐ Physically Disabled Date of Disability: _____ | Pregnant ☐ Yes ☐ No Due Date: _____

Father's Name | Is Father: ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed | Mother's Name | Is Mother: ☐ Deceased ☐ Incapacitated ☐ Absent ☐ Unemployed

Child living in Home ☐ Yes ☐ No

Ethnic Group (Check all that apply) ☐ Alaskan Native ☐ American Indian ☐ Armenian ☐ Asian Indian ☐ Black/African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hispanic/Latino ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ Other Asian or Pacific Islander (Specify): _____ ☐ Other (Specify): _____

OTHERS IN HOME

6 Is there anyone living in your home that you did not list? If yes, list name and relationship:

Name | Relationship

Name | Relationship

HEALTH INSURANCE

7 Is anyone currently covered by health/dental insurance or Medi-Cal?

☐ Yes ☐ No Who Pays _____ Monthly Amount _____

List Name(s)

List Name of Insurance

ADDITIONAL INFORMATION

8 Additional Information:

OTHER SERVICES

9 Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of personal needs?

If yes, list name(s)

10 Are you currently receiving any health or social services?

☐ Yes ☐ No, If yes, please list:

11 Do you want to talk to a worker about other services which may be available to you?

☐ Yes ☐ No If yes, briefly describe:

CERTIFICATION

CERTIFICATION

I understand that it is important to provide information on this Universal Face Sheet and any of its supplemental form(s) that is true and correct, and I have done so to the best of my abilities. If any information is not correct, I understand that it may affect my ability to receive services.

Signature of Applicant/Beneficiary | Date

Signature of Person Helping Applicant Fill Out the Form | Date

Phone Number | Relationship to Applicant/Beneficiary

Signature of Interpreter | Date

Phone Number | Relationship to Applicant/Beneficiary

WAIVER

WAIVER

For the purposes of receiving services, I give permission to share this information with other service providers.

Signature of Applicant | Date

# of Attachments: